

GLOSSARY

MEDICAL HOME

Access: The ability to get needed medical care and services.

Accessibility of Services: The ability to get medical care and services when you need them.

Developmentally Appropriate Care: Care that is tailored or suitable for a particular level of mental, physical or emotional development.

Comprehensive: Care that is broad in scope, encompassing all aspects of a patient's care needs.

Continuity of Care: Complete care that is provided during all transitions, such as hospital to home, home to hospital, etc. Planning ensures linkages with education, health, and community resources.

Coordinated care: The system that has services which are coordinated to assure timeliness, appropriateness, continuity, and completeness of care.

Commonwealth Fund: The Commonwealth Fund is a private foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund, based in New York City, carries out this mandate by supporting independent research on health and social issues and making grants to improve health care practice and policy. The Fund's two national program areas are improving health insurance coverage and access to care and improving the quality of health care services. The Fund is dedicated to helping people become more informed about their health care, and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. (www.cmwf.org)

Culturally Competent Health Care: The application of cultural knowledge, behaviors, and interpersonal and clinical skills that enhance a provider's effectiveness in managing patient care.

Culturally Effective Care: Clinical and preventive care that is evidence-based, flexible, authentic, and ethical. Interventions need to be appropriately tailored to patients, families, and communities, with attention to racial, ethnic, socioeconomic and other differences, while being aware of personal attitudes, beliefs, biases, and behaviors that may influence (consciously or unconsciously) care of patients.

Family Centered: Patient care that has not only the patient as it's focus but also considers the family constellation and how it impacts delivery of patient care.

Medical Home Index: A measurement tool that allows physicians to assess their practices according to medical home standards

HEALTH LITERACY

Active Listening: demonstrated through nonverbal behavior such as making eye contact with and smiling at the person talking with you. Openness is demonstrated when listening by your physical proximity to and relative position to the subject. This type of listening requires effort and is not "natural" for many people but it is important in the clinical setting.

Comprehension: To take in, understand. Unfortunately, with patient education materials readability doesn't always insure patient comprehension or understanding.

Functional Health Literacy: Refers to a person's capacity to function in the health care setting and is determined by literacy, or the comprehension of written health care materials, and numeracy, or the ability to understand and act on numerical health care instructions. Examples of functional health literacy include the ability to read, comprehend, and follow instructions on a prescription bottle, appointment slip, or patient education flyer/handout.

Health Literacy: Is defined by ability to read, understand and act appropriately on health care information. It incorporates several skills, including basic reading and numerical tasks, decoding instructions or diagrams, and analyzing health information such as weighing risks and benefits.

National Health Literacy Act: “For purposes of this Act the term “literacy” means an individual's ability to read, write, and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential.” Public Law 102-73, the National Literacy Act of 1991, 102nd Congress -- 1st Session, July 25, 1991.

Non-verbal Signals: In person-to-person communications our messages are sent on two levels simultaneously. If the nonverbal cues and the spoken message are incongruous, the flow of communication is hindered. Right or wrong, the receiver of the communication tends to base the intentions of the sender on the non-verbal cues he receives. **Non-verbal communication** includes facial expressions, eye contact, tone of voice, body posture and motions, and positioning within groups. It may also include the way we wear our clothes or the silence we keep.

Parentalism: A parent's attitude of dominance over one or more children. For example, a parent stating “I'm the boss around this house” is a demonstration of parentalism.

Patient Autonomy: Recognizes the right of the patient to make informed decisions about his/her health care.

Plain Language: reflects the interests and needs of an individual patient rather than the legal, bureaucratic, or technological interests of the health care system. This language means more that what you say when interacting with patients – it also refers to how you say it. Choose common words, speak slowly and limit the amount of information given.

Quality of Care: Refers to the degree to which health care services meet the needs of the patient and increases the likelihood of desired health outcomes.

Readability Formulas: Readability formulas have been developed to assist writers in preparing information. These formulas provide a means for estimating the difficulty a reader may have reading and understanding a paragraph, section or entire document.

REALM: Rapid Estimate of Adult Literacy in Medicine (REALM), a screening instrument designed to be used in public health and primary care settings to identify patients with low reading levels. It provides reading grade estimates for patients who read below a ninth-grade level. The REALM can be administered in one to two minutes by personnel with minimal training, and provides an estimate of patient reading ability, displays excellent concurrent validity with standardized reading tests, and is a practical instrument for busy primary care settings.

SMOG formula: The SMOG Readability Formula is a simple method you can use to determine the reading level of your written materials. If a person reads at or above a grade level, they will understand 90-100% of the information. Generally, writers need to aim for a reading level of sixth grade or less. The SMOG conversion tables were developed by Harold C. McGraw, Office of Educational Research, Baltimore Co. Public Schools, Towson, MD.

Teach-back Method: The “teach-back” method allows students to become the teacher and to much more thoroughly understand and internalize information. Having patients repeat the information or instructions as they would tell them to a friend or provide a return demonstration of a procedure is an easy way to verify that they understand what they are supposed to do.

Partnership for Clear Health Communication: A coalition of national organizations that are working together to promote awareness and solutions around the issue of low health literacy and its effect on health outcomes.

TOFHLA: was developed at Georgia State University under a grant to Emory University from the Robert Wood Johnson Foundation and was first published in 1995. It is used to measure functional health literacy--both numeracy and reading comprehension--using actual health-related materials such as prescription bottle labels and appointment slips.

MEDICAID

Amount, Duration, and Scope: The phrase used to describe the Medicaid program policy under which states are allowed to limit the items and services they cover within a statutory benefit category (e.g. physician inpatient hospital

prescription drug). Each benefit category that a state covers must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

AVRS: Automated Voice Response System, a spoken response to queries entered on a touch tone phone provided by EDS for Medicaid providers (1-800-727-7848).

Assignment: The Medicaid program policy under which hospitals, physicians, nursing facilities, and other providers that elect to participate in Medicaid must accept as payment in full the program's payment for an item or service delivered to a Medicaid beneficiary and may not "balance bill" or charge the beneficiary any additional amount. If the state's Medicaid program imposes nominal cost sharing on certain categories of Medicaid beneficiaries for certain services, the providers of those services may seek payment of the allowable cost-sharing amounts directly from the beneficiary.

Capitation: A specified dollar amount given to a plan, or provider, to provide necessary services for the enrolled persons. It is expected that some people will use less than this amount, thereby costing less than the amount while other people will use more, thus balancing the risk for the provider.

Capitation Payment: A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. See fee-for-service, MCO, Risk Contract.

Case Management: A process by which the services provided to a specific enrollee are coordinated and managed to achieve the best outcome in the most cost-effective manner.

Case Mix: A measure that reflects the severity of illness, diagnoses, resource use, use of services, or type of patients that are in a provider's caseload.

Case Rate: A fixed reimbursement amount depending on the type of case (hip replacement, normal newborn delivery). This payment generally includes both physician and hospital charges, limits the liability of the payor and shifts some of the financial risk to the provider. This concept is similar to referral-based or contact capitation.

Categorical Eligibility: A phrase describing Medicaid's policy of restricting eligibility to individuals in certain groups or categories, such as children, the aged, or individuals with disabilities. Certain categories of individuals—e.g., childless adults under 65 without disabilities—are generally ineligible for Medicaid regardless of the extent of their impoverishment. Individuals who fall into approved categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the states in which they reside. See Financial Eligibility.

Categorically Needy: A phrase describing certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. There are "categorically needy" groups that states participating in Medicaid are required to cover, such as pregnant women and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL). There are also "categorically needy" groups that states may at their option cover, such as pregnant women and infants with incomes above 133 percent and up to 185 percent of the FPL. Unlike the "medically needy," "categorically needy" individuals may not "spend down" in order to qualify for Medicaid.

Center for Medicaid and State Operations (CMSO): The agency within the Centers for Medicare and Medicaid Services (CMS) with responsibility for administering Medicaid and the Children's Health Insurance Program (CHIP).

Centers for Medicare and Medicaid Services (CMS): The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).

Certified Emergency: An emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses and average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any bodily organ or part.

Children's Health Insurance Program (SCHIP): Enacted in the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both). The statutory federal matching rate for SCHIP services (on average, 70 percent) is higher than that for Medicaid (on average, 57 percent), but the federal allotment to each state for CHIP services is capped at a specified amount each year. Also referred to as the State Children's Health Insurance Program (SCHIP).

Comparability: A rule of Medicaid benefits design that requires a state to offer services in the same amount, duration, and scope to one group of categorically needy individuals (e.g., poverty-related children) as it offers to another group of categorically needy individuals (e.g., elderly SSI recipients). See Amount, Duration, and Scope; Categorically Needy.

CMS Waivers: Agreements with the federal government that allow states flexibility in the administration of their state's Medicaid plan.

Concurrent Review: An assessment of the medical necessity or suitability of services that occurs as the services are being provided.

Crosswalking: An example of crosswalking would be if new test is determined to be similar to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is then assigned the related existing local fee schedule amounts and resulting national limitation amount. In some instances, a test may only equate to a portion of a test, and, in those instances, payment at an appropriate percentage of the payment for the existing test is assigned.

Drug Utilization Review (DUR): The program of prospective and retrospective review of prescriptions paid for by a state Medicaid program that each state is required to conduct in order to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Disallowance: A determination by CMS not to provide federal Medicaid matching payments to a state in connection with an expenditure made by the state's Medicaid program because the expenditure does not meet federal requirements for matching payments. States may appeal CMS disallowances to the Departmental Appeals Board (DAB) and to federal court.

DSS: Medicaid's Decision Support System. DSS contains databases that allow for the extraction of claims information for use in reports

Dual Eligibles: Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.

EDS (Electronic Data System): Alabama Medicaid's fiscal agent

Episode of Care: The treatment provided for a specific condition over a defined period of time.

Explanation of Benefits (EOB): Written, formal statement sent to enrollees that lists the services.

Fair Hearing: Because Medicaid is an entitlement, individuals have a statutory right to appeal denials or terminations of Medicaid benefits to an independent arbiter. The fair hearing is the administrative procedure that provides this independent review with respect to individuals who apply for Medicaid and are denied enrollment, individuals enrolled in Medicaid whose enrollment is terminated, and Medicaid beneficiaries who are denied a covered benefit or service.

Federal Financial Participation (FFP): The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs, depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative cost. See FMAP.

Federal Medical Assistance Percentage (FMAP): The statutory term for the federal Medicaid matching rate - i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 83 percent depending upon a state's per capita income; on average, across all states, the federal government pays at least 57 percent of the costs of Medicaid. FMAPs for administrative costs vary not by state, but by function. The general FMAP for administrative costs is 50 percent; some functions (e.g., survey and certification, fraud control units) qualify for enhanced FMAPs of 75 percent or more.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference

Federally Qualified Health Center (FQHC): States are required to include services provided by FQHCs in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by "look alike" clinics that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.

Financial Eligibility: In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify for coverage.

Formulary: States that elect to cover prescription drugs in their Medicaid programs may limit the drug products covered through the use of a formulary, a listing of the specific drugs for which a state will make payment without prior authorization. States may exclude from their formularies specific drugs of manufacturers participating in the Medicaid rebate programs only if certain criteria are met and only if the excluded drug is made available through a prior authorization program.

Freedom of Choice: Refers to both the right of providers to choose whether or not to participate in the Medicaid program and the right of Medicaid beneficiaries to choose providers from among those participating. This right with respect to beneficiaries is commonly waived in states implementing Medicaid managed care.

Freedom of Choice Waiver: Section 1915(b) Waiver

Medicaid: A federal program to provide medical benefits to specific groups of low income and/or eligible persons; administered at the state level.

Medicaid Fee Schedule: The actual fees that the state Medicaid program will pay (to a provider or facility) for services provided to an enrollee.

Medicaid Management Information System (MMIS): A state's computer systems for tracking Medicaid enrollment, claims processing, and payment information. The 1996 HIPAA legislation requires that each state's MMIS have the capacity to exchange data with Medicare. It also contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.

Medicaid MCO: A Medicaid MCO provides comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.

Medical Assistance: The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state's Medicaid program on behalf of individuals eligible for benefits.

Medically Needy: A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid's categorical requirements - i.e., they are children or parents or aged or individuals with disabilities - but their income is too high to enable them to qualify for "categorically needy" coverage. Instead, they qualify for coverage by "spending down" - i.e., reducing their income by their medical expenses. States that elect to cover the "medically needy" do not have to offer the same benefit package to them as they offer to the "categorically needy."

Medical Necessity: A legal term indicating that the service is medically appropriate, necessary to meet the person's health needs, consistent with the person's diagnosis, and consistent with established standards of care.

Medicare Buy-in: The informal term referring to the payment of Medicare Part B premiums on behalf of low-income Medicare beneficiaries who qualify for full Medicaid coverage (dual eligibles) or just for assistance with Medicare premiums and cost-sharing (Qualified Medicare Beneficiary, Specified Low-Income Beneficiaries, and Qualifying Individual).

Memorandum of Understanding (MOU): A written agreement between a Medicaid PMP and another physician or facility which will allow that physician/facility to use the PMP's referral number for payment of services.

Outstationing: The placement of state or local Medicaid eligibility workers at locations other than welfare offices. State Medicaid agencies are required to outstation workers at DSH hospitals and FQHCs to accept Medicaid applications from poverty-related pregnant women and children.

Prior Authorization: A mechanism that state Medicaid agencies may at their option use to control use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, the state Medicaid agency will not pay unless approval for the item or service is obtained in advance by the beneficiary's treating provider, either from state agency personnel or from a state fiscal agent or other contractor.

Qualified Medicare Beneficiary (QMB): A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is at or below 100 percent of the federal poverty line (FPL) and whose countable resources do not exceed \$4000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, and all required deductibles and coinsurance (up to Medicaid payment amounts).

Qualifying Individual (QI): Between January 1998 and December 2002, States are required to pay all or a portion of Medicare premiums on behalf of a limited number of Medicare beneficiaries known as "Qualifying Individuals," or QIs. Unlike other categories of low-income Medicare beneficiaries (e.g., dual eligibles, QMBs, and SLIMBs), QIs are not entitled to this assistance, but are enrolled on a first-come, first-served basis each year up to the limit established by each state's allotment of federal funds for this purpose. QIs have incomes from 120 to 175 percent of the federal poverty level (FPL) and countable resources of up to \$4,000.

Rebate: The amounts paid by manufacturers to state Medicaid programs for outpatient prescription drugs purchased by the programs on behalf of eligible beneficiaries on a fee-for-service basis. Rebates are calculated on the basis of the average manufacturer price (AMP) for each drug and, in the case of brand name drugs, on the basis of the manufacturer's best price. A manufacturer must agree to pay rebates in order for federal Medicaid matching funds to be paid to states for the costs of the manufacturer's drug products.

Resources: Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home). Some Medicaid eligibility groups must meet a resource test; others (at state option) are not subject to a resource test. In establishing a resource test, a state Medicaid program must specify both the resource standard (e.g., the amount of countable resources an individual may retain) and the resource methodology (e.g., which resources are counted and how are they valued).

Single State Agency: The agency within state government designated as responsible for administration of the state Medicaid plan. The single state agency is not required to administer the entire Medicaid program; it may delegate most administrative functions to other state (or local) agencies or private contractors (or both). However, all final eligibility determinations must be made by state (or local) agency personnel.

Specified Low Income Medicare Beneficiary (SLMB): A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is above 100 percent and not in excess of 120 percent of the federal poverty line (FPL) and whose countable resources do not exceed \$4000. SLMBs, like QMBs are eligible to have Medicaid pay their Medicare monthly premiums, but unlike QMBs are not eligible for Medicaid payment for their Medicare cost-sharing obligations.

Spousal Impoverishment: The term used to describe the set of eligibility rules that states are required to apply in the case where a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the

institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse.

State Medicaid Plan: Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet 64 federal statutory requirements.

State Plan Amendment (SPA): A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.

Statewideness: The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, 1915(b), and 1915(c) waivers.

Transfer of Assets: Refers to the practice of disposing of countable resources such as savings, stocks, bonds, and other real or personal property for less than fair market value in order to qualify for Medicaid coverage. When such transfers occur, it is usually in connection with the anticipated or actual need for long-term nursing home care. Federal law limits (but does not entirely prohibit) such transfers.

Transitional Medical Assistance (TMA): Refers to Medicaid coverage for families with children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.

Waivers: Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available. Under Section 1915(b) waivers, states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.

Upper Payment Limit (UPL): Limits set forth in CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds. The UPLs generally are keyed to the amounts that can reasonably be estimated would be paid, in the aggregate, to the class of providers in question using Medicare payment rules. In the case of MCOs, the UPL is specific to each plan and is tied to the amounts that would have been paid under Medicaid on a fee-for-service basis.

GENERAL

AAFP: American Academy of Family Physicians

AAP: American Academy of Pediatrics, an organization of 57,000 pediatricians committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. The AAP web site (www.aap.org) contains general information for parents of children from birth through age 21 as well as information regarding the Academy's many programs and activities, policy statements and practice guidelines, publications and other child health resources.

Accreditation: An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

ADA: Americans with Disabilities Act

American Association for Home Care: An industry association for the home care industry, including home IV therapy, home medical services and manufacturers, and home health providers. AAHC was created through the merger of the Health Industry Distributors Association's Home Care Division (HIDA Home Care), the Home Health Services and Staffing Association (HHSSA) and the National Association for Medical Equipment Services (NAMES).

Ancillary Services: Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

AskMe3: Asking 3 is a quick, effective tool designed to improve health communication between patients and providers. Through patient and provider education materials developed by leading health literacy experts **Ask Me 3** promotes three simple but essential questions that patients should ask their providers in every health care interaction. Providers should always encourage their patients to understand the answers to: 1) **What is my main problem?** 2) **What do I need to do?** 3) **Why is it important for me to do this?**

Benchmark: A benchmark is sustained superior performance by a medical care provider, which can be used as a reference to raise the mainstream of care for Medicare beneficiaries. The relative definition of superior will vary from situation to situation. In many instances an appropriate benchmark would be a provider that appears in the top 10% of all providers for more than a year.

CATCH: Community Access to Child Health

Chronic Illness and Disability Payment System (CDPS): This payment system, formerly the Disability Payment System (DPS) was designed to more fairly compensate health plans that serve people with disabilities or residents of low-income areas.

Clinical Risk Groups (CRG's): This payment system, formerly the Classification of Congenital and Chronic Health Conditions, was developed as a population-based system to classify individuals with congenital and chronic health conditions. The system assigns each person with a chronic condition to a severity level. There are four uses of CRGs: 1) tracking congenital/chronic disease prevalence rates, 2) describing health service utilization and physician practices, 3) adjusting pricing and capitation, and 4) linking to measures of patient satisfaction/quality tracking.

Consolidated Omnibus Budget Reconciliation Act (COBRA)*: COBRA is a law that makes an employer let the employee remain covered under the employer's group health plan for a period of time after: the death of a spouse, losing a job, or having work hours reduced, or getting a divorce.

Continuum of Care: A variety of available services that meets the needs of the covered population in an appropriate and cost-effective manner.

Coordinated care: The system that has services that are coordinated to assure timeliness, appropriateness, continuity, and completeness of care.

CSHCN: Children with special health care needs. They have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and require health related services of a type or amount beyond that required by children generally (Federal Maternal and Child Health Bureau, 1995).

Current Dental Terminology: A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

Current Procedural Terminology (CPT): A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

CYSHCN: Children and youth with special health care needs (see CSHCN).

D-Codes: Subset of the HCPCS Level II medical codes identifying certain dental procedures. It replicates many of the CDT codes and will be replaced by the CDT. Descriptor: The text defining a code in a code set.

Designated Code Set: A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.

Diagnostic Related Groups (DRGs): A classification system for service payments based on a person's diagnosis.

Disease Management: An approach that coordinates services around a specific diagnosis in order to minimize the negative effect of the illness.

Disability Management: A strategy to control the costs of disabilities by preventing their occurrence, reaching the best recovery for those that do occur, and working towards the return to work or school.

Discharge Planning: A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.

Disclosure: Release or divulgence of information by an entity to persons or organizations outside of that entity.

Disclosure History: Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

DME: Durable medical equipment; equipment that is not disposable such as wheelchairs, walkers, oxygen concentrators.

DRG Coding: The DRG (Diagnosis Related Groups) categories used by hospitals on discharge billing.

DSM: Diagnostic and Statistical Manual of Mental Disorders, a classification system for mental illnesses.

Family Centered Care: The system of care that recognizes and builds upon the importance of the family and reflects this in the way services are planned and delivered. It promotes family/professional partnerships and responds to family identified needs, builds upon family strengths, and respects the diversity of families.

Family Voices: A national grassroots organization of families and friends speaking on behalf of children with special health care needs.

Family-to-Family Health Information Centers: Centers run for and by families of children and youth with special needs to provide information, resources, training, and advocacy to ensure families are making informed health care decisions and have access to necessary medical care.

Federation of Families for Children's Mental Health (FFCMH): A nationally affiliated, parent-run organization focused on the needs of children and youth with emotional, behavioral or mental disorders and their families.

Freedom of Information Act (FOIA): A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government, not to those of the Congress or Federal courts, and does not apply to state governments, local governments, or private groups.

Gate Keeping: The use of primary care clinicians, case managers or some other mechanism as the initial contact for care in order to ensure that only appropriate and cost-effective services are utilized.

HCPCS (pronounced "hick-picks"): The acronym for the common procedure coding system that is a uniform method for healthcare providers and medical suppliers to report professional services, procedures, and supplies.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, which requires each state's Medicaid management information system (MMIS) to have the capacity to exchange data with the Medicare program and contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.

Health Maintenance Organization (HMO): A health care organization that meets the following characteristics (1) it offers an organized system for providing health care within a specific geographic area; (2) it provides a set of basic and supplemental health maintenance and treatment services; and (3) it provides care to an enrolled group of people; there are four basic models of HMO's: group model, individual practice association model, network model and staff model.

Health Plan Employer Data and Information Set (HEDIS): A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost, and other measures to compare managed care plans. The Centers for Medicare & Medicaid Services (CMS) collects HEDIS data for Medicare plans. (See Centers for Medicare & Medicaid Services).

Home- and Community-Based Services (HCBS) Waiver: Also known as the "1915(c) waiver" after the enabling section in the Social Security Act, this waiver authorizes the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home and community-based services, which otherwise would not qualify for federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

Hospitalist: A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over care from the primary doctor when a patient is in the hospital, keep the primary doctor informed about progress, and will return the patient to the care of the primary doctor when discharged from the hospital.

IDEA: Individuals with Disabilities Educational Act

Independent Practice Association (IPA) Model HMO: A type of HMO in which a contracted entity subcontracts with clinicians to provide health care services in return for a contracted fee.

Integrated Behavioral Health Network: A carved-out health plan that combines various managed behavioral health care services in a single, coordinated delivery system.

Integrated Delivery System: An organized delivery system that provides comprehensive health care.

Intergovernmental Transfer (IGT): The transfer of non-Federal public funds from a local government (or locally owned hospital or nursing facility) to the state Medicaid agency, or from another state agency (or state-owned hospital) to the State Medicaid agency, usually for the purpose of providing the state share of a Medicaid expenditure in order to draw down federal matching funds. Often used in connection with payments to DSH hospitals and UPL transactions.

J-Codes: A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items.

Joint Commission on Accreditation of Healthcare Organizations: An organization that accredits healthcare organizations. In the future, the JCAHO may play a role in certifying these organizations' compliance with the HIPAA A/S requirements.

Length of Stay (LOS): The duration of a period of care for a covered person.

Liability Risk: The risk of change in the likelihood of a lawsuit.

Literacy: The National Literacy Act defines literacy in the United States as "an individual's ability to read, write, and speak in English, and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential." Literacy is related to multiple aspects of health, including health knowledge, health status, and use of health services.

Locum tenens: A physician who temporarily substitutes for another.

Long term care: Health maintenance and health services, including respite, home and personal care, for people with chronic conditions, disabilities, or mental illness. Services can be provided in a community or institution.

Managed Care: A system of care that manages the cost of health care while increasing and ensuring access to quality care.

Managed Care Organization (MCO): An organization that provides a managed health care plan that uses various approaches to control the cost and utilization of services, promote their quality and measure performance to ensure cost-effectiveness.

Managed Health Care Plan: A single service product that combines the financing, administration and delivery of health care services for an enrolled population.

Management Service Organization (MSO): An organization that provides management and administrative support services to individual clinicians and group practices.

Mandatory: State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all do, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as “mandatory” in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds.

Medical Home: According to the AAP, medical home is an approach to providing health care services in a high-quality and cost-effective manner. Patients who have a medical home receive the care that they need from a physician whom they trust. The practitioner, the patient and the family or caretaker act as partners in a medical home to identify and access all the medical and non-medical services needed to help the patient achieve his/her maximum potential. The care received should be accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.

NAMI: National Alliance for the Mentally Ill, a national organization with state affiliates focusing on advocacy, information, and resources for individuals with mental illness and their families.

National Center for Health Statistics: A federal organization within the CDC that collects, analyzes, and distributes health care statistics. The NCHS maintains the ICD-n-CM codes.

National Committee for Quality Assurance (NCQA): An organization that sets standards, evaluates, and accredits HMO's and other managed health care organizations.

NICHY: National Information Center for Children and Youth with Disabilities.

Noncompliance: The failure of the patient to cooperate by carrying out that portion of the medical care plan under his or her control, e.g., not taking prescribed medicines or not adhering to a diet as ordered. Noncompliance may be deliberate, as with patients who deliberately ignore or defy orders, or unintentional, as a consequence of the patient's literacy.

OASIS: Outcome Assessment Information Set, an outcome measurement tool of the process of service delivery through the use of creative approaches, monitoring, feedback, and organizational learning.

Ombudsman: An advocate (supporter) who works to solve problems between residents and nursing homes, as well as assisted living facilities.

PES: Provider Electronic Solutions, computer software available at no charge to Medicaid providers from Medicaid's fiscal agent, EDS (Electronic Data System)

PMP: Primary Medical Provider

PMPM: Per member per month; an amount paid to a provider for services to the enrollee population, a flat rate per member.

Practice Guidelines: Descriptions of sound medical practice that assist clinicians in making decisions regarding health care provided for specific medical conditions.

Preferred Provider Organization (PPO): An organization that contracts with specific providers to provide

primary and secondary diagnoses, demographics and complicating factors.

Primary Care Provider (PCP): The provider that provides primary, preventative, and non –specialty care, generally from family practice, internal medicine, and pediatrics.

Primary Care Case Manager (PCCM): PCCMs are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled beneficiaries. State Medicaid contracts with PCCMs tend to be less comprehensive in their coverage of benefits and involve less financial risk than those with MCOs.

Privatization: Generic term referring to efforts to move functions formerly carried out by governmental entities to private for-profit or not-for-profit entities.

Process Improvement: A methodology utilized to make improvements to a process through the use of continuous quality improvement methods.

Process Indicator: A gauge that measures a goal-directed interrelated series of actions, events, mechanisms, or steps.

Profiler: A written analysis of claims data which produces characterizations of providers and recipients, as well as comparisons of providers with their peer group. The report is derived from processing data obtained from claims information.

Prospective Reimbursement: Payment to service providers over a period of time before the services are delivered.

Provider Tax: A tax, fee, assessment, or other mandatory payment required of health care providers by a state. States may use revenues from provider taxes to pay the state share of Medicaid spending only under limited circumstances specified in federal Medicaid law.

PSN: Provider Service Network, a network of providers that provide services under contract for a managed care group or organization.

PTI: Parent Training and Information Centers

Report Card: A way to rate and compare the performance of health plans or individual providers.

Respite Care: Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take some time off.

Sanctions: Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the OIG to deal with questionable, improper, or abusive behaviors of providers under the Medicare, Medicaid, or any State health programs.

SCHIP: State Children's Health Insurance Program, a program that establishes a health insurance program for children without insurance from families whose income is too high for Medicaid but below established formulas.

Section 1115 Waiver: Under section 1115 of the Social Security Act, the Secretary of HHS is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal Medicaid matching funds. In 2001, 19 states were operating Medicaid section 1115 waivers affecting some or all of their eligible populations and involving \$27 billion in federal matching funds, or one fifth of all federal Medicaid spending that year. The waivers, which are granted (or renewed) for 5-year periods, are administered by CMS.

Section 1915(b) Waiver: Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers, which are granted (or renewed) for 2-year periods, are administered by CMS.

Section 1931 Eligibility/Medicaid for Low Income Families (MLIF): Under section 1931 of the Social Security Act, states must extend Medicaid eligibility to parents (and older children) in families who meet the eligibility requirements that

were in effect under their state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996. States have the option under section 1931 to raise the eligibility levels for these parents through the use of "less restrictive" income and resource methodologies

SOBRA: Sixth Omnibus Budget Reconciliation Act - Official name for the SOBRA Program.

Spend Down: The process of using up all income and assets on medical care costs to become eligible for a program, usually Medicaid.

SSA: Social Security Administration that oversees SSI and SSDI.

SSDI: Social Security Disability Income, set dollar amount paid to eligible persons and their dependents when they have lost their jobs due to a disability.

SSI: Supplemental Security Income, paid to eligible recipients to offset income loss due to a disability.

Supplemental Security Income (SSI): A federal entitlement program that provides cash assistance to low-income aged, blind, and disabled individuals. Individuals receiving SSI benefits are eligible for Medicaid coverage in all states except "section 209(b)" states, which have opted to use their more restrictive 1972 criteria in determining Medicaid eligibility for SSI recipients. See Section 209(b).

Temporary Assistance for Needy Families (TANF): A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program. Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may but are not required to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

Third Party Liability (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. For example, if a Medicaid beneficiary is also eligible for Medicare, the Medicare program is liable for the costs of that beneficiary's hospital and physician services, up to the limit of Medicare's coverage. From the Medicaid program's standpoint, Medicare is a liable third party. Other examples of TPL include private health insurance coverage, automobile and other liability insurance, and medical child support.

Title IV (4): Section of the Social Security Act that focuses on aid and services to needy families with children and welfare services.

Title V (5): Maternal and Child Health program that focuses on health issues of women and children.

Title X (10): Section of the Social Security Act that focuses on aid to persons who are blind.

Title XIV (14): Section of the Social Security Act that focuses on persons who are permanently and totally disabled.

Title XIX (19): Section of the Social Security Act that focuses on Medicaid.

Title XVI (16): Section of the Social Security Act that focuses on Supplemental Security Income (SSI).

Title XVIII (18): Section of Social Security Act that focuses on Medicare.

Title XXI (21): State Children's Health Insurance Program (SCHIP).

Title XIX: Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title V (MCH block grant), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (SCHIP).

Vaccines for Children (VFC) Program: A program under which the federal government, through the Centers for Disease Control and Prevention, purchases and distributes pediatric vaccines to states at no charge and the state

in turn arranges for the immunization of Medicaid-eligible and uninsured children through public or private physicians, clinics, and other authorized providers.

WRAT-R: The Wide Range Achievement Test--Revised, designed to "measure the codes which are needed to learn the basic skills of reading, spelling, and arithmetic", is the sixth edition of the popular test that was first published in 1936. Like the earlier versions, the WRAT-R contains three subtests: Reading (recognizing and naming letters and words), Spelling (writing symbols, name, and words), and Arithmetic (solving oral problems and written computations).